EXHIBIT A

EXCERPTS FROM THE DEPOSITION OF RAHUL GUPTA, M.D.

09/11/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

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THE CITY OF HUNTINGTON,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01362

AMERISOURCEBERGEN DRUG CORPORATION, et al.,

Defendants.

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CABELL COUNTY COMMISSION,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01665

AMERISOURCEBERGEN DRUG CORPORATION, et al.,

Defendants.

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Videotaped and videoconference deposition of RAHUL GUPTA, M.D., taken by the Defendants under the Federal Rules of Civil Procedure in the above-entitled action, pursuant to notice, before Teresa S. Evans, a Registered Merit Reporter, all parties located remotely, on the 11th day of September, 2020.

about?

A. I'm sorry, can you repeat that, please?

Q. Sure. What is your understanding of this case? What is it about?

A. My understanding is that this case is related to the number of overdose deaths and generally the suffering and the carnage that has occurred broadly in the state of West Virginia, but narrowly in Cabell County and the City of Huntington as a result of oversupply as well as the over-availability of prescription opioids and the consequences resulting from that.

Q. And what is the basis of your understanding? How did you come to have that understanding?

A. As I had mentioned before, that including my work as the Commissioner for the Bureau of Public Health as well as the State's chief health officer, having worked in this area, having read the reports as well as public records and accounts and have been deposed and involved in the workings of the Department of Health and Human Resources of West Virginia, is how I come about to have that understanding.

information and opinions about other issues, so if he's asked the questions, he'll respond.

A. I think one of the challenges for me is to be able to differentiate between what case and what specific legalities, so do let me know on that aspect as you ask those questions.

Q. I will, Doctor. Your answer is perfectly fine. I understood what you meant. Thank you. I just want to have one little clarifying question. When you said, "solve the problem we're facing," do you mean the opioid abuse problem in West Virginia?

A. Yes. And the public health ensuing crisis.

Q. Thank you. Doctor, do you have a general understanding of the system of distribution for prescription opioids?

A. My role as the State Health Commissioner and public health officer, I have a broad bird's eye view of the understanding of the system of distribution.

Q. What is that understanding, sir?

A. My understanding is that based on the quota that's determined by the DEA, manufacturers are able to produce the volume of those pills and then the distributors are able to - as registrants of

getting into clinical practice. I could not tell you exactly, but approximately -- I finished my residency was in 1999, so that would have been around the years based on my license, permitted license, that I would have filled out that process.

So I would be aware of the DEA registration process since that time.

Q. I see. Thank you. I -- my question was confusing. We started by talking about the system of distribution for controlled substances. When did you become generally aware of that system of distribution?

A. So it was -- it was more during my term as the health commissioner and the state health officer because I was engaged in addressing the opioid crisis and the public health consequences that I became more aware and became more in contact with the Board of Medicine, the Board of Pharmacy and the controlled substances monitoring program and that was the time during which I came to know much more about the process than I had previously.

Q. And beyond the requirements for all of the actors in the supply chain to be DEA registrants, what else have you learned about the -- that

You said you focus on the opioid -- detailing the opioid crisis in that class. Does your investigation include the causes of the opioid epidemic?

A. We have a discussion on the description of charts and historical perspective. We created -- I ordered - as one of the first acts of being a Commissioner - a historical perspective report that - it's online available - of West Virginia's opioid crisis from 2000 to 2015 data.

I take several pieces of information from that report, that's a public report, done under -- I believe, it was Governor Justice. And I use that as an example to talk about historical. We talk about, obviously, all aspects/facets -- it's a pandemic -- it's an epidemic of epidemics.

We talk about all the consequences that are happening. And then we talk about things that we're doing to solve. The bottom line is, we do talk about, you know, how we got here; but our focus often is: How do we fix this?

And we want, you know, in West Virginia our students to understand that while we didn't break it, we'll have to fix it. And we're going to

the epidemic - at least the ones that you have the most information on - is that prescribers wrote too many prescriptions for opioids?

A. Could you please restate that question?

Q. Yes. Let me put it this way: Why do you discuss the volume of prescriptions in West Virginia and in the rest of the nation as part of this presentation focusing on supply-side factors?

A. Because the total volume that was available had a direct relationship and a correlation with the death and destruction that was happening related to overall overdoses in the state of West Virginia.

Q. And when you say that the "total volume that was available," do you mean the total volume of prescriptions?

A. "Prescription" is a surrogate for the amount of pills that were flowing through in communities across towns of West Virginia.

Q. And the number of prescriptions are a surrogate for the number of pills why, in your opinion?

A. Because that is probably the closest way for a public health commissioner like me to be able

to correlate. I would not have access to the actual data other than published reports, you know, to the tune of what we found later to be 780 million or what have you pills.

We at the time - as I recollect - weren't really aware of actual numbers, or we were close to aware of that -- being aware of that, but at the same time, prescriptions is the way to have the pills out there. I mean, there is appropriate prescribing and there is inappropriate prescribing.

But at the end of the day, it is through prescriptions that the flow of the pills are gonna end up there and be diverted.

Q. Okay, Doctor, I think we're almost at noon now. Why don't we go ahead and take that lunch break for about, say, until 12:30 and then we can come back and opposing counsel can take their -- do their questioning?

A. Okay.

MR. COLANTONIO: Okay, thank you.

THE DEPONENT: Thank you.

VIDEO OPERATOR: Going off the record. The time is 11:53 a.m.

(A recess was taken for lunch after

like to see the work that we had done replicated across the country and other areas as well.

We've had also -- hosted the then-secretary of HHS, Tom Price, as well as the counsel to the president, you know, to demonstrate and showcase what was happening in West Virginia with Kellyanne Conway.

Q. And I've heard this term before of social autopsy. Have you heard that term often?

A. Yes. We -- so we seeing the declines in death about 10 to 15 to 20 percent each year during my tenure from 2016 and prior to that to -- finally in 2017, I asked -- one of the responsibility of the Commissioner is to be able to produce reports. So I asked my department to work at cross structures in West Virginia - for example, the Medicaid program, the EMS program, the Office of Medical Examiner, the Board of Pharmacy, the Board of Medicine - payors, to create a social autopsy.

What that meant was: We went back to all of the thousand or so deaths in 2016 from overdose and we basically conducted - a simplistic way to say it - a CSI-type of investigation.

So we up and did, we wanted to learn

from the dead to help inform those who are living.

And one of the ways we did that is: We looked at every single death and we investigated their past one year prior to death and understand what happened, what led to them dying, and then we cataloged that and published that report.

That report helped form -- helped us form an opioid task force where we brought in experts from Johns Hopkins, Marshall University, West Virginia University, as I had helped create the Office of Drug Control Policy under the supervision of the State Health Office and Commissioner at the time.

The drug czar that I hired who was the former police chief of Huntington, West Virginia, he led this task force that came up with recommendations that then subsequently resulted in two pieces of legislation - the Senate Bill 273 and Senate Bill 272 in 2018 - one of which was called the Opioid Reduction Act.

Now, back to the social autopsy, why we ended up with the Senate -- two Senate bills essentially passing unanimously for both parties and being signed by the Governor is because of the

the monster is off their head.

"Now when I go to my family, I can actually have a conversation and remember it with my family. I can start to feel feelings. I feel I've come back from death. I can watch television, I can remember and I can understand what's happening."

So that piece -- it allows these medications allow you not to worry about just seeking your next fix; it allows you to actually get a job, have a purpose in life, rebuild your community, rebuild your family and actually be able to function.

Q. All right. So turning back to the evolution of this opioid problem in West Virginia, did you at some point see an evolution, a change, from opioids to heroin?

A. As I came in as the Commissioner in 2015, I think that evolution was occurring. I think we were starting to see some of the laws that had been taking place in 2012-2013 -- certainly Governor Tomblin had initiated the Governor's Advisory Committee on Substance Abuse and some of the results were happening.

So we had a sliver of hope at the time that, "Listen, I think we're starting to see a light at the end of the tunnel" in the sense that, look, we're seeing slight reductions, and that's in the presentation you saw where I showed from 2015 to 2016, we went down 15 percent.

So we were becoming very hopeful that now perhaps the deaths will follow, meaning reduction in deaths and suffering and other things.

Q. I'm sorry, you said reduction -- reduction in --

A. Reduction in deaths.

Q. I'm sorry, you said you saw a slight reduction --

A. Reduction in prescriptions. So we started to see from 2015 to 2016, about a 15 to 20 percent reduction in opioid prescriptions.

Q. Okay.

A. And then we were hopeful that we would start to see a reduction in deaths. But we didn't. And then we started to search that why that we're seeing reduction in prescribing but we're not seeing reduction in the deaths from overdose; we're not seeing significant reduction in the substances

of overdose people when they died.

And one of the elements that was happening at the time that, again, now it's easier -- a little bit more easier to recognize, is that every time law enforcement would go and do a drug bust of the bad docs, those people would end up on the street that once were addicted to medication -- prescription medications, now would have to find -- seek and find an alternative, and they would go to the street.

And then they started to use IV drugs, heroin. That was not the only reason it was happening. It was also because the supply of prescription drugs from a diversion standpoint was drying up a little bit.

So as the diverted drugs - opioid prescription drugs - were drying up, then people still needed that fix, as I explained the addiction pathway. That doesn't solve the problem. We were too naive to think just reducing the prescription -- diversions would just cure the problem.

And what actually happened is the opioid crisis began to evolve -- evolve into a second crisis, which would then started to become

this heroin crisis. As we were dealing with that current crisis within the first, a third crisis, which is --

You know, everyone asking -- you know, wanting to make most profit from its product, and we saw the -- this happen, the phenomenon happen, with -- where people were dealing heroin, frankly. So they found -- they realized that they could get a bigger profit if they were -- if they could cut their heroin with another substance that could still give the high or give the need that needs to be fed to the people.

That was called fentanyl. It was a clandestine lab-produced fentanyl that's about 50 to 100 times more potent than morphine. So they would -- they began to cut the heroin with this substance on the street.

The problem that became for people who are addicted is: A, they wouldn't know that; the second, B, every time they inject themselves, not only are they risking HIV or hepatitis or what have you, but they're also basically playing Russian roulette with their life, because they wouldn't know if this is the time they were going to die/